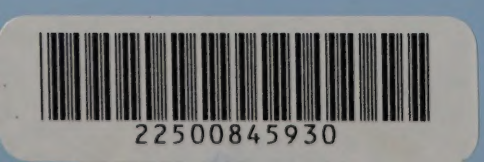
THE HEALTH OF THE NATION

A SUMMARY OF

THE STRATEGY FOR HEALTH IN ENGLAND



This booklet summarises the proposals for a health strategy for England, set out in the White Paper "The Health of the Nation: A Strategy for Health in England" (Cm 1986), obtainable from HMSO.

INTRODUCTION BY THE SECRETARY OF STATE FOR HEALTH

"The Health of the Nation" Green Paper, published in June 1991, stimulated an extensive public debate. More than 2,000 individuals and organisations sent in their views. Dozens of conferences, seminars and workshops were held. Newspaper and journal articles were written debating the issues raised.

Of course, many different views were expressed. But one thing above all was apparent: the very wide backing which the overall strategy set out in the Green Paper attracted. There was support for the need to concentrate on health promotion as much as health care; for the need to set clear and challenging targets – and not too many of them – at which to aim; and for the need for all of us to work together. These principles are essential if we are to make further significant improvements in the health of the people. The consultation showed that the time is right for the development of a strategic approach to health. It also confirmed the opportunities which exist.

The quality of the debate has revealed a common perception of what needs to be done. It has exposed the commitment which exists to make sure this is achieved. We are well placed to meet the targets set in this White Paper. If we succeed, the health of the nation will be substantially improved.

The Green Paper acknowledged our debt to the World Health Organisation's "Health For All" strategy. I was particularly heartened by the warm welcome which WHO gave to our Green Paper. Now we will build on this, in a way designed to meet the particular circumstances in this country.

The priorities, the targets, the mechanisms and the action set out in this document speak for themselves. I should, however, like to emphasise four points.

First, there is a commitment in this White Paper to the pursuit of 'health' in its widest sense, both within Government and beyond. Within Government

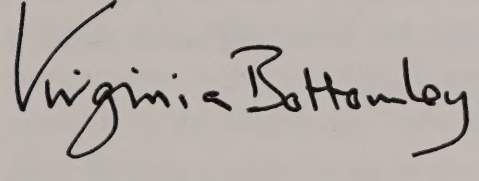
this reflects not only my role as Secretary of State for Health but also the responsibilities of my colleagues in other Departments.

Second, the reforms of the NHS have made this strategic approach possible. The need to focus on health as much as health care has long been the ambition. The reforms have enabled us to make it a reality.

Third, although there is much that Government and the NHS need to do, the objectives and targets cannot be delivered by Government and the NHS alone. They are truly for the nation – for all of us – to achieve. We must be clear about where responsibilities lie. We must get the balance right between what the Government, and Government alone, can do, what other organisations and agencies need to do and, finally, what individuals and families themselves must contribute if the strategy is to succeed.

Fourth, this White Paper is not the last word. It is only the start of a continuing process of identifying priority objectives, setting targets and monitoring and reviewing progress. Over time new objectives and targets will be set, adding to or replacing those in this White Paper.

This initiative is unique. It builds on achievements, both past and present. It proposes action and provides the focus for that action. Its ultimate purpose is to bring about further continuing improvement in the health of the nation.



Virginia Bottomley
Secretary of State for Health
Whitehall
LONDON

July 1992

SUMMARY OF THE STRATEGY FOR HEALTH

The aim of the consultative document "The Health of the Nation" was to stimulate a period of widespread public and professional debate on health and how it might be improved. This White Paper sets out a strategy for health for England which takes account of the response to consultation. The strategy

- selects five Key Areas for action
- sets national objectives and targets in the Key Areas
- indicates the action needed to achieve the targets
- outlines initiatives to help implement the strategy
- sets the framework for monitoring, development and review.

THE STRATEGIC APPROACH

The strategy is set against the background of a continuing overall improvement in England's general state of health. It emphasises disease prevention and health promotion as ways in which even greater improvements in health can be secured, while acknowledging that further improvement of treatment, care and rehabilitation remains essential.

KEY AREAS FOR ACTION AND NATIONAL TARGETS

Five Key Areas, in which substantial improvement in health can be achieved, are selected. Each Key Area has national targets, and is supported by action needed to secure progress. In the main, the targets relate to the year 2000, but some look further to the future. Within Key Areas, emphasis is placed on risk factors, such as smoking or dietary imbalances.

The Key Areas are:

- Coronary heart disease and stroke
- Cancers
- Mental illness
- HIV/AIDS and sexual health
- Accidents.

WORKING TO TAKE THE STRATEGY FORWARD

Everyone has a part to play if the strategy is to be successful. At national level the Government has set up a Ministerial Cabinet Committee to co-ordinate Government action and oversee implementation of the health strategy. Others with major roles include the NHS and health professions, statutory and other authorities, the Health Education Authority, voluntary bodies, employers and employees, and the media.

The importance of active partnerships between the many organisations and individuals who can come together to help improve health ("healthy alliances") are also highlighted. Action on a wide variety of fronts will include work in "settings" such as healthy cities, healthy schools or healthy hospitals, specific action on general health promotion in the workplace and of the environment at large.

THE PARTICULAR ROLE OF THE NHS

The NHS has a particularly important role in improving health in addition to its responsibilities for health care. Not only will it work towards achieving progress in the national Key Areas, but it will add to them identified local priorities. The success of the strategy will depend to a great extent on the commitment and skills of the health professionals within the NHS.

MONITORING, DEVELOPING AND REVIEWING THE STRATEGY

The strategy must be monitored and the tools to do so developed. A range of action to meet information and research needs, including major new health survey work, is put in hand. Monitoring and reviewing progress will be overseen by the Ministerial Committee on Health Strategy, assisted by the three Working Groups set up at the start of the initiative. Periodic progress reports will be published.

THE STRATEGY FOR HEALTH

The Government's overall goal is to secure continuing improvement in the general health of the population of England by:

adding years to life: an increase in life expectancy and reduction in premature death; and

adding life to years: increasing years lived free from ill-health, reducing or minimising the adverse effects of illness and disability, promoting healthy lifestyles, physical and social environments and, overall, improving quality of life.

These concepts are not new. They are an integral part of the World Health Organisation's "Health For All by the Year 2000" approach. The Government acknowledges the important contribution of the "Health For All" approach in the formulation of the strategy for health in England.

Success will come through, for example:

public policies: by policy-makers at all levels, not only across Government but also in other public bodies and industry, considering the health dimension when developing policies;

healthy surroundings: by the active promotion of physical environments conducive to health – in the home, in schools, at work, on the roads, at leisure, in public places;

healthy lifestyles: by increasing knowledge and understanding about how the way people live affects their health, and enabling families and individuals to act upon this;

high quality health services: by identifying and meeting the health needs of local populations and securing the most appropriate balance between health promotion, disease prevention, treatment, care and rehabilitation.

Success will also depend on monitoring the population's health, and on research to determine the most effective ways of improving health. This will show how and where resources can be deployed to maximum advantage.

The need for monitoring and research is especially important in tackling the variations in health between different groups in the population which exist here as in every other country. Effective strategies, whether national or local, will need to be sensitive to these variations, and to focus on the settings in which they are most evident. It will be necessary to identify the variations that occur in particular health problems in order to concentrate efforts on people at particular risk, and to adopt different strategies for different groups. This is discussed further throughout the appendix.

No-one is immortal, but in many cases the onset of illness can be prevented or delayed. When illness strikes, treatment aimed at cure or rehabilitation will continue to be of prime importance. But it is of equal importance to promote good health and well-being, thus preventing illness in the first place. The strategy therefore highlights improving and maintaining **health**, not simply **health care**.

This strategy is about making the best use of the resources the nation as a whole devotes to health. So far as the Department of Health and the NHS are concerned, it means that decisions about the use of available resources for new initiatives (service or otherwise), research and development and health monitoring should reflect the priorities in this White Paper.

KEY AREAS, OBJECTIVES AND TARGETS

The Government believes that improvements should, and can, be made in all aspects of health. However, the first step in a strategic approach must be the establishment of clear priorities so that action and resources can be directed to best effect. This is necessary because if everything is regarded as a 'priority' then there is, in effect, no priority at all.

The Government therefore proposes that the strategy for health should be founded on selected **Key Areas** where there is both the greatest need and greatest scope for making cost-effective improvements in the overall health of the country. For each Key Area, this White Paper sets out the overall **objectives** for improved health, and specific **targets** to be met by set dates. Such targets have a central place in the strategic approach because they clarify what might otherwise be no more than general good intentions. They enable all concerned – whether Government, other bodies or individuals – to focus their efforts on common objectives and provide a yardstick for measuring achievement.

Three criteria, set out in "The Health of the Nation" Green Paper, governed this first selection of the Key Areas:

- the area should be a major cause of premature death or avoidable ill-health
- effective interventions should be possible, offering significant scope for improvement in health
- it should be possible to set objectives and targets, and monitor progress towards them.

Key Areas represent the beginning of a rolling programme for priority action. The Green Paper discussed 16 possible areas and many others were suggested in the consultation. A large number were considered, but for a variety of reasons, not all met the criteria. These included:

- areas with existing initiatives which are sufficiently well developed not to require the status of a Key Area, and where the emphasis must be on sustaining and building on progress which has been made already – such as maternal and child health; food safety; oral health; childhood imunisation (for which the Government has set a target of 95% uptake by 1995, the existing national target of 90% for all such immunisations having been achieved in May 1992).
- strong candidates for Key Area status where the Government believes that further development and research is necessary before national targets can be set – such as rehabilitation; health of elderly people; asthma; back pain; drug misuse.

Three other areas discussed in the Green Paper – diabetes, hospital acquired infection (HAI) and breastfeeding – are not selected as Key Areas. They are, nevertheless, important. For example, the Government has asked the Clinical Standards Advisory Group to advise on standards of clinical care for people with diabetes and also to take forward preliminary work on HAI with a view to providing further advice in this area. With regard to diabetes, protocols are already being developed, with the prospect that the targets in the 1989 St Vincent's Declaration (concerned with improving the care and quality of life for people with diabetes) will be achieved as practice improves. In the case of breastfeeding the Government proposes to set up a national working group to help identify and take forward action to increase the proportion of infants breastfed both at birth and at six weeks.

THE INITIAL KEY AREAS

At the start, the strategy will be based around five priority areas – the Key Areas.

- ***Coronary heart disease and stroke*** During the consultation there was virtually unanimous agreement that the prevention of coronary heart disease and stroke should be included as a Key Area because of the scope for preventing illness and death from these conditions, and because reductions in risk factors associated with them – unbalanced diet, smoking, raised blood pressure, alcohol misuse and lack of physical activity – would also help to prevent many other diseases.
- ***Cancers*** The prevention of cancer was selected because of the toll that cancers take in ill-health and death, and because some, but not all, cancers can now be prevented (by actions such as not smoking or avoiding over-exposure to sunlight), and cured as a result of screening and early detection.
- ***Mental illness*** This was selected because it affects many people and because there is much that can and should be achieved, particularly in relation to improvements in services to reduce the harm that mental illness can cause.
- ***HIV/AIDS*** This was included because it is perhaps the greatest new threat to public health this century. The related areas of *sexual health* and *family planning* are also very important to the health and well-being of individuals and families.

- ***Accidents*** The prevention of accidents was included because accidents are an important cause of injury, disability and death, particularly in young and elderly people, and can very often be avoided.

The Key Areas, the objectives and targets which flow from them, and the action needed to secure progress are summarised in the following pages. The targets are main targets[1], indicated by ruled boxes, and risk factor targets. Early tasks in all the Key Areas will be to assess further their implications for the use of available resources and to identify the most efficient and effective ways of meeting the targets.

In framing action within Key Areas the needs of specific groups of people within the population must be considered; the particular needs of children, women, elderly people and people in black and ethnic minority groups and certain socio-economic groups are also considered in the appendix to the White Paper.

Success in these Key Areas would represent a significant improvement in the nation's health in terms of life expectancy, reductions in premature death and improvements in quality of life. Success would also mean resources could be re-deployed to improve services in those areas where, as yet, effective preventive measures are not available.

[1] The 1990 baseline for all mortality targets represents an average of three years centred around 1990.

CORONARY HEART DISEASE AND STROKE

Objective – to reduce the level of ill-health and death caused by coronary heart disease and stroke, and the risk factors associated with them.

Coronary heart disease (CHD) accounted for about 26% of deaths in England in 1991. It is both the single largest cause of death, and the single main cause of premature death. Strokes were responsible for approximately 12% of all deaths in 1991.

TARGETS

To reduce death rates for both CHD and stroke in people under 65 by at least 40% by the year 2000 (from 58 per 100,000 population in 1990 to no more than 35 per 100,000 for CHD, and from 12.5 per 100,000 population in 1990 to no more than 7.5 per 100,000 for stroke).

To reduce the death rate for CHD in people aged 65 to 74 by at least 30% by the year 2000 (from 899 per 100,000 population in 1990 to no more than 629 per 100,000).

To reduce the death rate for stroke in people aged 65 to 74 by at least 40% by the year 2000 (from 265 per 100,000 population in 1990 to no more than 159 per 100,000).

Figures 1 and *2* show trends in death rates from CHD and stroke.

STRATEGY

Because all the main risk factors for CHD and stroke can be influenced, much of the premature death and ill-health associated with heart disease and stroke is potentially preventable. Attention therefore needs to be focused on:

Smoking

Smoking accounts for up to 18% of CHD deaths and 11% of stroke deaths. The Government's target is:

To reduce the prevalence of cigarette smoking in men and women aged 16 and over to no more than 20% by the year 2000 (a reduction of at least 35% in men and 29% in women, from a prevalence in 1990 of 31% and 28% respectively).

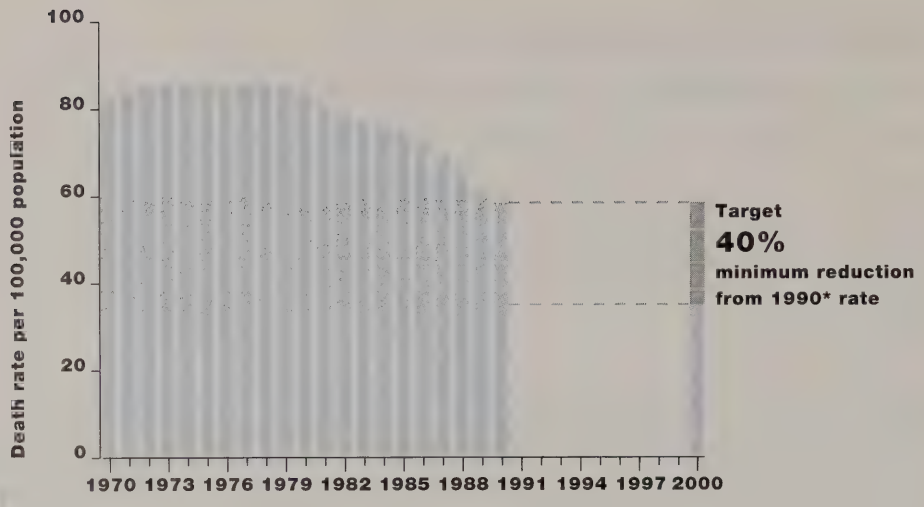
– see the following section on cancers for full smoking targets –

Death rates for Coronary Heart Disease

Figure 1

England 1970-1990*• and target for the year 2000

All persons aged under 65°

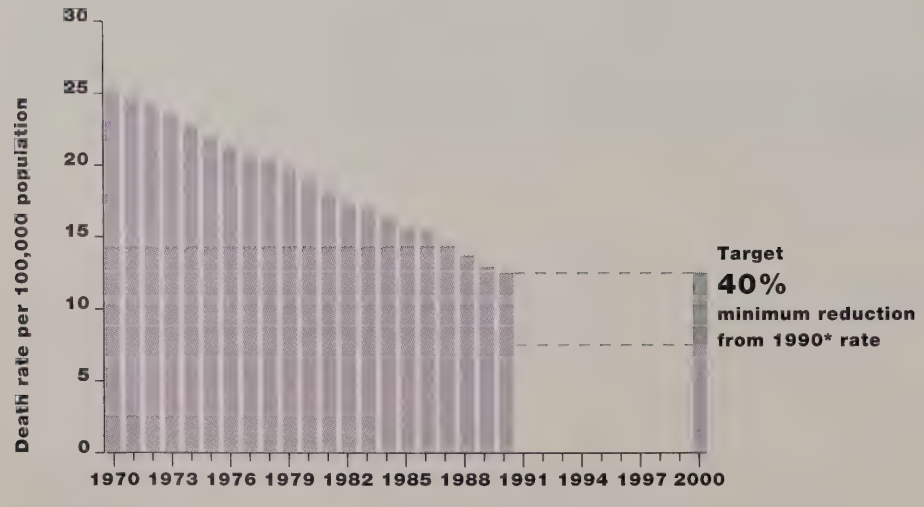


Source: OPCS (ICD 410:414)

Death rates for Stroke

England 1970-1990*• and target for the year 2000

All persons aged under 65°



Source: OPCS (ICD 430:438)

* Rates are calculated using a 3 year average plotted against the middle year of average

• The change in classification between the years 1978 and 1979, and a change in coding procedures between 1983 and 1984 may affect the comparability of the data

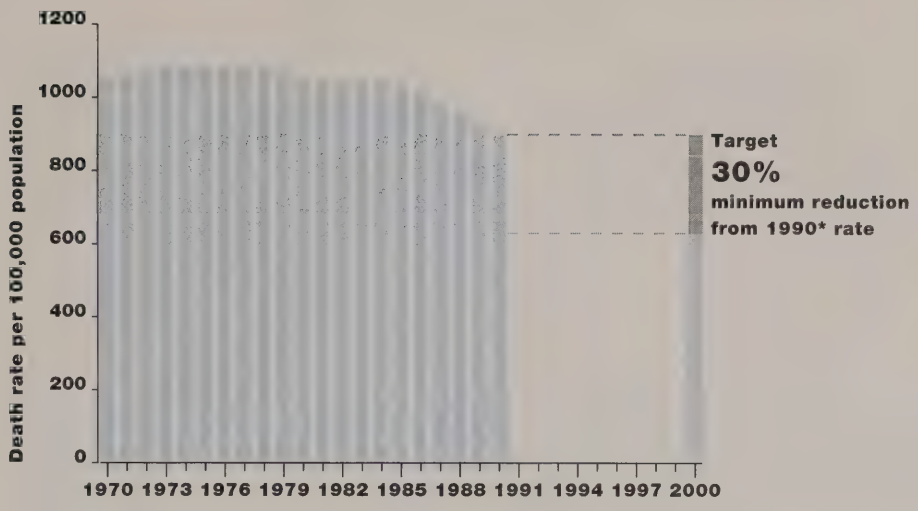
° Rates are calculated using the European Standard Population to take into account differences in age structure

Figure 2

Death rates for Coronary Heart Disease

England 1970-1990*• and target for the year 2000

All persons aged 65-74

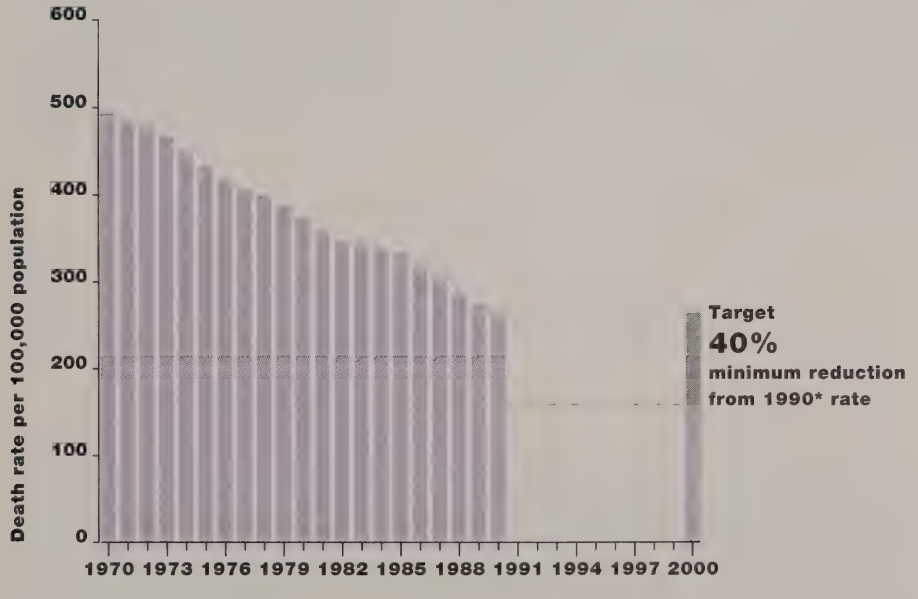


Source: OPCS (ICD 410:414)

Death rates for Stroke

England 1970-1990*• and target for the year 2000

All persons aged 65-74



Source: OPCS (ICD 430:438)

* Rates are calculated using a 3 year average plotted against the middle year of average

• The change in classification between the years 1978 and 1979, and a change in coding procedures between 1983 and 1984 may affect the comparability of the data

Eating and Drinking Habits

Plasma cholesterol is the most important risk factor for CHD. Plasma cholesterol levels are higher in people who eat a high proportion of saturated fatty acids and in those who are overweight and obese. It has been estimated that a reduction of 10% in the average plasma cholesterol level might result in a 20-30% reduction in CHD deaths. Targets are therefore:

To reduce the average percentage of food energy derived by the population from saturated fatty acids by at least 35% by 2005 (from 17% in 1990 to no more than 11%).

To reduce the average percentage of food energy derived by the population from total fat by at least 12% by 2005 (from about 40% in 1990 to no more than 35%).

To reduce the percentages of men and women aged 16-64 who are obese by at least 25% for men and at least 33% for women by 2005 (from 8% for men and 12% for women in 1986/87 to no more than 6% and 8% respectively).

Excessive consumption of alcohol and sodium, together with obesity, contribute to raised blood pressure, which is the main risk factor for stroke.

It has been estimated that a reduction in mean blood pressure of 5mm Hg could result in a 10% reduction in deaths from CHD and stroke. Additional targets are therefore:

To reduce mean systolic blood pressure in the adult population by at least 5mm Hg by 2005.

To reduce the proportion of men drinking more than 21 units of alcohol per week from 28% in 1990 to 18% by 2005, and the proportion of women drinking more than 14 units of alcohol per week from 11% in 1990 to 7% by 2005.

Physical Activity

Appropriate physical activity can also help reduce risk of CHD and stroke. The Government proposes to publish targets for physical activity in the light of the results of the Allied Dunbar National Fitness Survey.

CONCLUSION

Success in achieving all these targets will lead to consequential improvements in many other conditions, eg reducing smoking prevalence and excessive alcohol consumption would lower the risk of certain cancers, and a reduction in obesity should reduce the risk of non-insulin dependent diabetes.

CANCERS

Objectives – to reduce ill-health and death caused by breast, cervical and skin cancer; to reduce ill-health and death caused by lung cancer – and other conditions associated with tobacco use – by reducing smoking prevalence and tobacco consumption throughout the population.

After coronary heart disease, cancers are the most common cause of death in England accounting for about 25% of deaths in 1991. There are many types of cancers. Understanding of their causes varies greatly, as does our ability to prevent, treat and cure them.

TARGETS

With present knowledge, the Government believes that there are four cancers – breast cancer, cervical cancer, skin cancer and lung cancer – for which it is now sensible to set specific outcome targets:

To reduce the death rate for breast cancer in the population invited for screening[1] by at least 25% by the year 2000 (from 95.1 per 100,000 population in 1990 to no more than 71.3 per 100,000).

To reduce the incidence of invasive cervical cancer by at least 20% by the year 2000 (from 15 per 100,000 population in 1986 to no more than 12 per 100,000).

To halt the year-on-year increase in the incidence of skin cancer by 2005.

To reduce the death rate for lung cancer by at least 30% in men under 75 and 15% in women under 75 by 2010 (from 60 per 100,000 for men and 24.1 per 100,000 for women in 1990 to no more than 42 and 20.5 respectively).

Figure 3 shows the trend in lung cancer deaths in men and women.

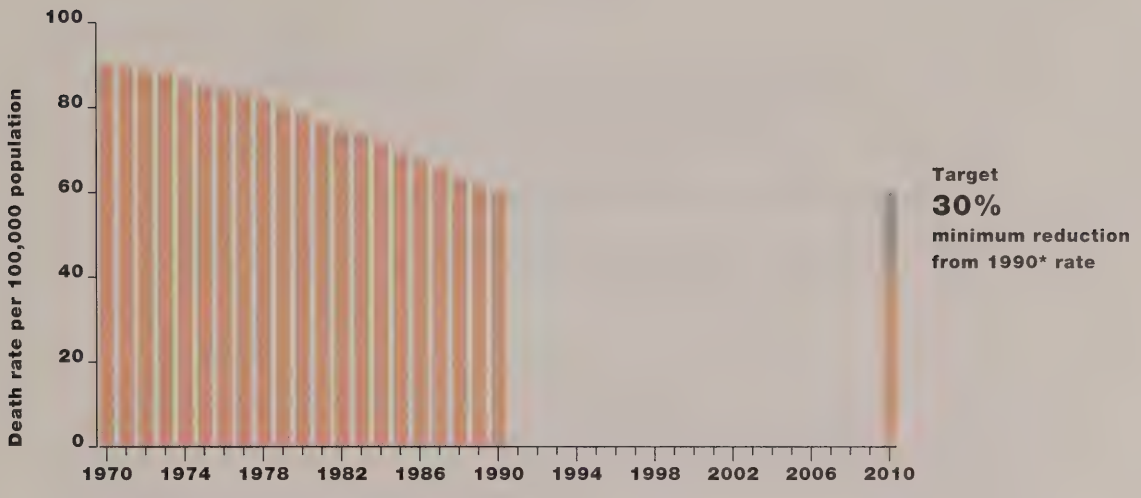
[1] Population invited for screening = all women aged 50 to 64 registered with a GP

Death rates for Lung Cancer

Figure 3

England 1970-1990* and target for the year 2010

Males aged under 75°

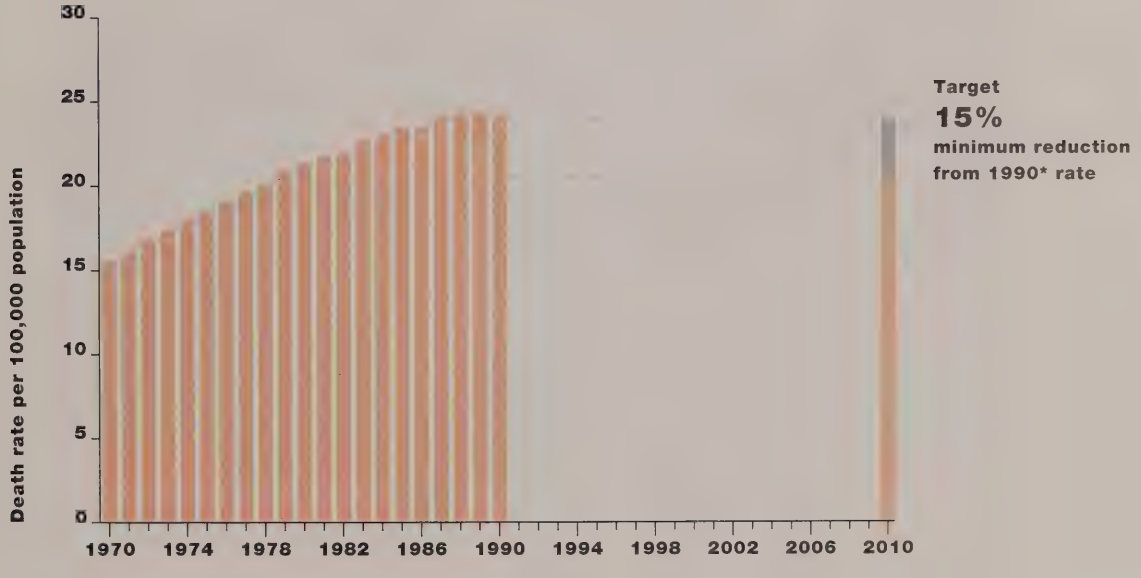


Source: OPCS (ICD 162)

Death rates for Lung Cancer

England 1970-1990* and target for the year 2010

Females aged under 75°



Source: OPCS (ICD 162)

*Rates are calculated using a 3 year average plotted against the middle year of average

° Rates are calculated using the European Standard Population to take into account differences in age structure

STRATEGY

For breast and cervical cancer, national screening programmes are in operation which aim to reduce rates of death from these diseases.

Of deaths from lung cancer, at least 80% are associated with smoking (some 26,000 deaths a year). Efforts therefore need to be directed at combatting the harmful effects of smoking. In particular:

To reduce the prevalence of cigarette smoking in men and women aged 16 and over to no more than 20% by the year 2000 (a reduction of at least 35% in men and 29% in women, from a prevalence in 1990 of 31% and 28% respectively).

In addition to the overall reduction in prevalence, at least a third of women smokers to stop smoking at the start of their pregnancy by the year 2000.

To reduce the consumption of cigarettes by at least 40% by the year 2000 (from 98 billion manufactured cigarettes per year in 1990 to 59 bn.).

To reduce smoking prevalence among 11-15 year olds by at least 33% by 1994 (from about 8% in 1988 to less than 6%)[1].

Success in reducing smoking will lead to improvements in various other conditions, including CHD, stroke, chronic bronchitis, peripheral vascular disease and low birthweight. It will also lead to a reduction in harm to non-smokers (particularly children) caused by environmental tobacco smoke.

[1] The target quoted is that of the Health Education Authority's Teenage Smoking Programme. Longer term targets will need to be considered at the end of the programme.

MENTAL ILLNESS

Objective – to reduce ill-health and death caused by mental illness.

Mental illness is a leading cause of ill-health and disability. It ranges from milder but more common conditions such as depression and anxiety, to the less common but more severe conditions like schizophrenia, affective disorders and dementia. Mental illness accounts for 14% of certificated sickness absence.

The main burden of mental illness is the ill-health and suffering it causes for individuals and their families and carers. In addition, it is also associated with many deaths from higher rates of physical illness and from suicide. There were 5,567 deaths from suicide (and undetermined injury) in 1991 in England. Suicide rates are influenced by many factors, but there is significant scope for improvement by the provision of better health care and other services. It is worthy of note that most people who commit suicide have recently been in contact with health services for some reason.

TARGETS

To improve significantly the health and social functioning of mentally ill people[1].

To reduce the overall suicide rate by at least 15% by the year 2000 (from 11.1 per 100,000 population in 1990 to no more than 9.4).

To reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (from the estimate of 15% in 1990 to no more than 10%).

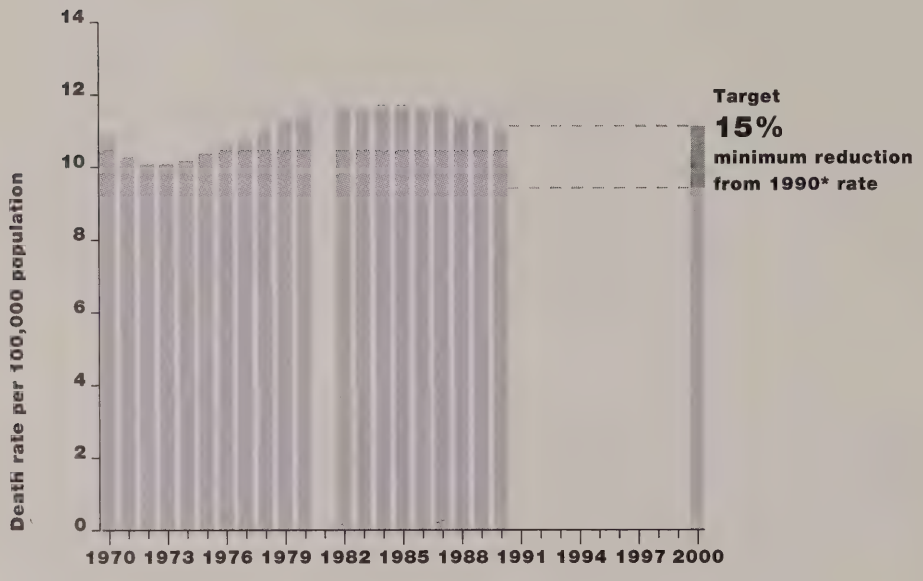
Figure 4 shows the trend in overall suicide rates, although within that there are significant age group differences.

[1] Limitations of current data mean that it is not feasible at present to set quantified targets for health and social functioning. A high priority will be to develop the means to set quantified targets.

Death rates for Suicide and Undetermined Injury *Figure 4*

England 1970-1990*• and target for the year 2000

All persons°



Source: OPCS (ICD E950:E959+E980:E989)

* Rates are calculated using a 3 year average plotted against the middle year of the average

• Data for 1981 were affected by industrial action by registrars and are excluded, thus rates for 1980 and 1982 are based on two year averages

° Rates are calculated using the European Standard Population to take into account differences in age structure

STRATEGY

The strategy to achieve these targets will need to be developed in three areas:

improving information and understanding – more extensive national and local data collection, standardised assessment procedures and clinical audit;

developing comprehensive local services – local joint purchasing and planning arrangements which ensure continuity of health and social care;

further development of good practice – education, training, protocols and standards of good practice.

HIV/AIDS AND SEXUAL HEALTH

Objectives – to reduce the incidence of HIV infection; to reduce the incidence of other sexually transmitted diseases; to strengthen monitoring and surveillance; to provide effective services for diagnosis and treatment of HIV and other STDs; to reduce the number of unwanted pregnancies; to ensure the provision of effective family planning services for those people who want them.

HIV infection is perhaps the greatest new public health challenge this century. It is, primarily, a sexually transmitted disease (STD). Other STDs are in themselves a cause of ill-health, and can have serious long-term consequences.

TARGET

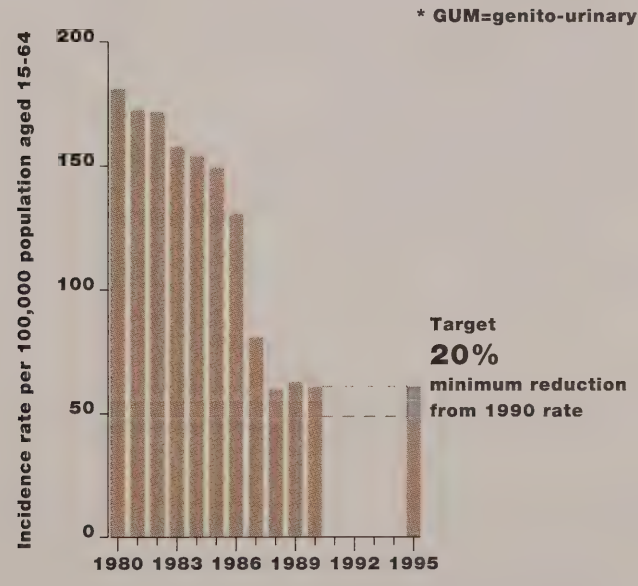
To reduce the incidence of gonorrhoea among men and women aged 15-64 by at least 20% by 1995 (from 61 new cases per 100,000 population in 1990 to no more than 49 new cases per 100,000)[1].

Figure 5 shows the trend in incidence of gonorrhoea.

New Cases of Gonorrhoea at GUM* Clinics *Figure 5*

England 1980-1990 and target for the year 1995

All persons



Source: Forms SBH60 and KC60 (from 1988)

[1] HIV may not produce symptoms until many years after infection. Gonorrhoea is therefore a better early marker of changes in sexual behaviour that will affect the spread of HIV. Achieving the target for gonorrhoea would therefore suggest that changes in behaviour had occurred which were likely to reduce the incidence of HIV and other STDs.

Effective family planning can have significant benefits for health, whereas unwanted or unplanned pregnancies can carry risks for the health of the whole family.

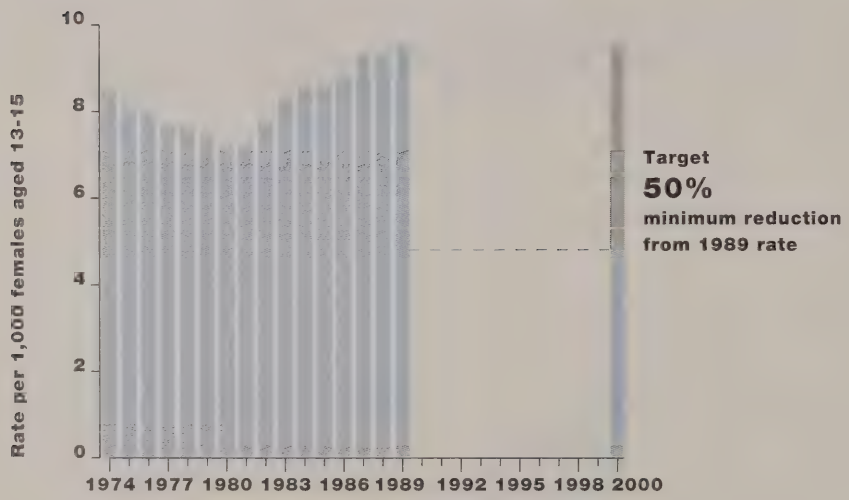
TARGET

To reduce the rate of conceptions amongst the under 16s by at least 50% by the year 2000 (from 9.5 per 1,000 girls aged 13-15 in 1989 to no more than 4.8)[1].

Conception Rates *Figure 6*

England 1974-1989 and target for the year 2000

Females aged under 16 years of age



Source: OPCS Birth Statistics

Figure 6 shows the trend in conceptions amongst under 16s.

[1] Information about all unwanted pregnancies is difficult to collect, but it is reasonable to make the general assumption that pregnancies in those under 16 are not wanted. It is a matter of concern that the conception rate in this age group is increasing. Measures to achieve this target may also be expected to exert a similar effect on unwanted pregnancies in those over 16.

STRATEGY

If the spread of HIV infection and other STDs is to be curbed, behaviour change on a wide scale is needed. There is no single measure to overcome the threat that HIV poses to public health. Success lies in:

- information and education
- monitoring and surveillance
- development of comprehensive local services.

HIV can also be transmitted by the sharing of drug injecting equipment. Therefore the Government proposes a target:

To reduce the percentage of injecting drug misusers who report sharing injecting equipment in the previous four weeks by at least 50% by 1997, and by at least a further 50% by the year 2000 (from 20% in 1990 to no more than 10% by 1997 and no more than 5% by the year 2000).

Reductions in unwanted pregnancies will also be dependent upon information and education and the continued development of local services. Family planning services should be appropriate, accessible and comprehensive, to meet the needs of those who use or may wish to use them.

ACCIDENTS

Objective – to reduce ill-health, disability and death caused by accidents or unintentional injuries[1].

Accidents are a major cause of avoidable death and injury. They are avoidable because few accidents are due solely to chance. They are the most common cause of death in people aged under 30, and they also contribute very significantly to ill-health and disability. They particularly affect the health of children, young adults and elderly people.

TARGETS

The Government therefore proposes targets for the groups of people at particular risk:

To reduce the death rate for accidents among children aged under 15 by at least 33% by 2005 (from 6.7 per 100,000 population in 1990 to no more than 4.5 per 100,000).

To reduce the death rate for accidents among young people aged 15–24 by at least 25% by 2005 (from 23.2 per 100,000 population in 1990 to no more than 17.4 per 100,000).

To reduce the death rate for accidents among people aged 65 and over by at least 33% by 2005 (from 56/7 per 100,000 population in 1990 to no more than 38 per 100,000).

These are in addition to the existing Department of Transport target of:

a reduction in road casualties in Great Britain of one third by the year 2000 (from a baseline of the average number of casualties in the years 1981 to 1985)

Trends in rates of death from accidents are shown in *Figure* 7.

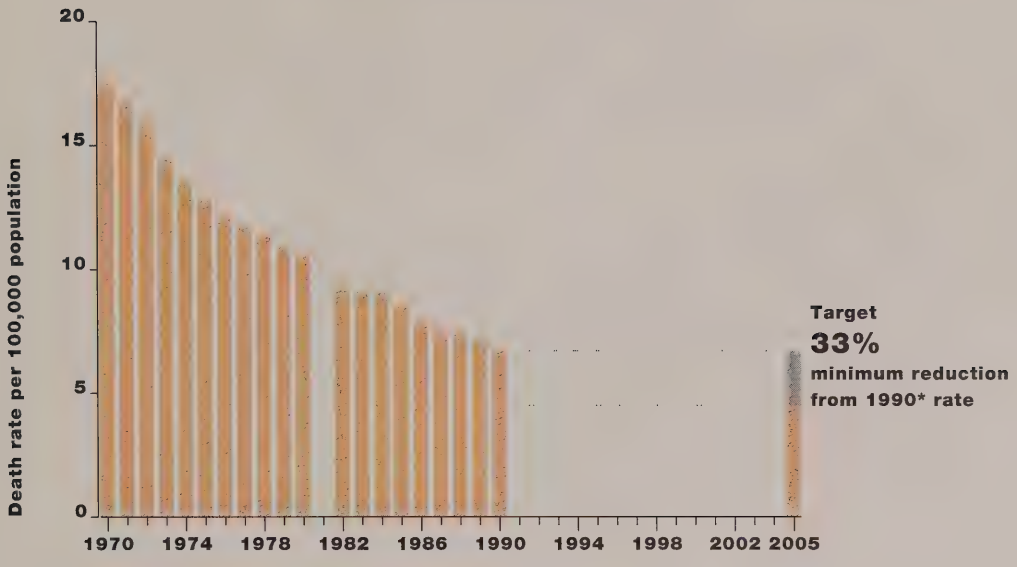
[1]Some prefer the term "unintentional injury" as conveying a better sense of the scope for prevention. This term may gain wider usage but for the sake of clarity and brevity "accident" is used throughout.

Death rates for Accidents

Figure 7

England 1970-1990 and target for the year 2005**

All persons aged under 15°



Source: OPCS (ICD E800:E949)

Death rates for Accidents

England 1970-1990 and target for the year 2005**

All persons aged 15-24

Source: OPCS (ICD E800:E949)

*Rates are calculated using a 3 year average plotted against the middle year of the average

•Data for 1981 were affected by industrial action by registrars and are excluded, thus rates for 1980 and 1982 are based on two year averages

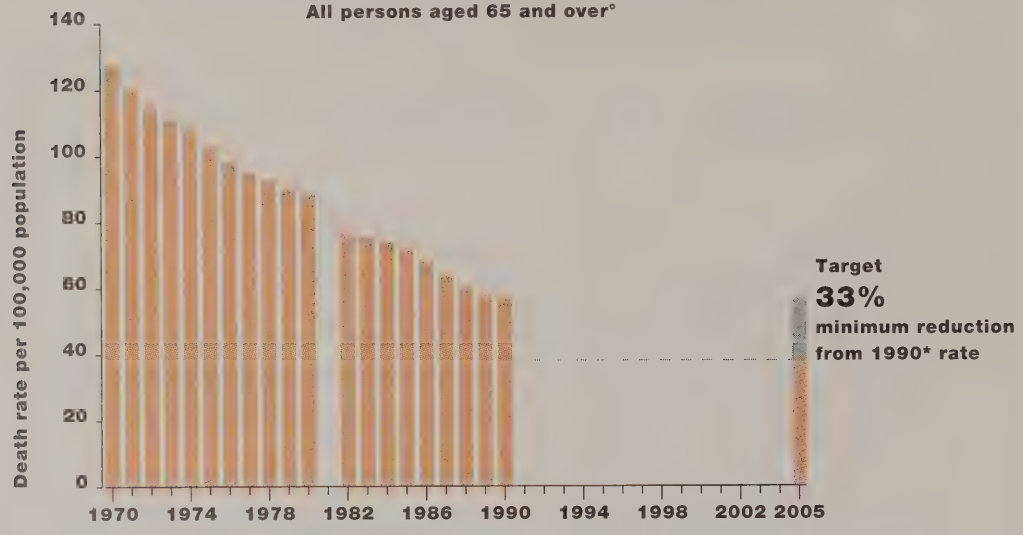
°Rates are calculated using the European Standard Population to take into account differences in age structure

Death rates for Accidents

Figure 7

England 1970-1990 and target for the year 2005**

All persons aged 65 and over°



Source: OPCS (ICD E800:E949)

*Rates are calculated using a 3 year average plotted against the middle year of the average

•Data for 1981 were affected by industrial action by registrars and are excluded, thus rates for 1980 and 1982 are based on two year averages

°Rates are calculated using the European Standard Population to take into account differences in age structure

STRATEGY

Few accidents occur purely by chance. Many are preventable through measures such as improved planning and design of the environment, education, better management in the workplace or greater vigilance and supervision in the home. The Government proposes to base its strategy around the key elements of:

- better co-ordination of agencies involved in accident prevention
- promotion of accident prevention as a public health issue
- better information
- action related to types of accidents
- action related to vulnerable groups of people.

WORKING TO TAKE THE STRATEGY FORWARD

The five Key Areas are at the centre of the strategy for health. The White Paper sets out action needed to reach the targets in each area. It also sets out action on a number of risk factors, such as smoking or excessive alcohol consumption, which relate to more than one Key Area.

- For **coronary heart disease and stroke**, there is a package of measures which includes commitments to at least maintain the real level of taxes on tobacco products; to encourage healthy eating, to tackle alcohol-related problems and to develop targets for physical exercise.

- For **cancers**, action will centre on smoking, with a range of proposals. Additional resources are being made available for a health education campaign to tackle teenage smoking and proposals will be developed for a major campaign aimed at adult smokers. There will be continued development of good practice in operating the cervical and breast screening programmes. Action is also proposed to help prevent skin cancer.

- The strategy for **mental illness** includes action to develop comprehensive local services and to continue to develop good practice, and to improve information and understanding.

- For **HIV/AIDS and sexual health**, the Government has developed a five part comprehensive strategy to protect against HIV, co-ordinated across all Government Departments. This covers prevention; monitoring, surveillance and research; treatment, care and support; social, legal and ethical issues and international co-operation. The development of family planning services will continue to be a priority for the NHS.

- For **accidents,** measures to improve co-ordination will include establishment of a task force to give a national lead on accident prevention, and action will be taken to improve information about the cause and treatment of accidents.

OPPORTUNITIES FOR ACTION

Everyone has a part to play if the strategy is to be successful – individuals, groups, bodies and organisations through to Government.

Government, as well as taking a range of practical measures to support the strategy, has set up the Ministerial Cabinet Committee Health Strategy to co-ordinate Government action and oversee implementation and development of the strategy in England. And to be responsible for ensuring proper co-ordination of UK issues affecting health.

Local authorities are responsible for a wide range of public services, many of which are linked with the strategy set out in the White Paper. These responsibilities include education, environmental control, environmental health and food safety, transport, housing and social services.

Voluntary organisations are in a unique position to enhance the health of the population. Between them they cover the whole range of health-related activity from the highly specialised to the general. They can play a significant part through self-help, providing services, community health, health education, fund-raising and support for research. The Government has made £250,000 available in 1992/93 through grants under Section 64 of the Health Services and Public Health Act 1968 to fund preliminary voluntary sector work directly related to "The Health of the Nation" initiative.

The media have a crucial role to play in providing individuals with the information necessary to make healthy choices.

The Health Education Authority (HEA) carries out national programmes of public education and provides a national stimulus for local activity in a variety of settings. The HEA will be reviewing its strategic aims and objectives in the light of the strategy for health.

Employers have long been required to provide safe working conditions. Increasingly, they are also recognising the benefits of a healthy workforce, while trades unions and staff associations are looking for more ways to improve the general health of their membership.

The role of health professionals will be crucial to the success of the strategy. Their opportunities to help and advise individuals, families and communities are unparalleled.

Active partnerships between the many bodies and individuals who can come together to help improve health will be central to success in reaching the targets in the White Paper. Such "healthy alliances" cover activity from the local to the national level. Healthy alliances either within individual Key Areas or across a number of them add significantly to the opportunities for progress towards the national targets.

Opportunities to work towards the achievement of the targets, and indeed of other improvements in health, will be similarly enhanced when action is taken in "settings". Such settings include:

- **healthy cities:** the Government will examine ways in which the Health For All Network, which supports this WHO initiative in England, can be further assisted to carry out the work, and to increase the number of localities taking part;
- **healthy workplaces:** a task force to examine and develop activity on health promotion in the workplace is to be set up;
- **healthy schools:** the Government will help develop in England the WHO initiative on healthy schools by seeking to set up a pilot network of health promoting schools;
- **healthy homes:** health professionals, particularly health visitors and general practitioners, have a major role in this setting;
- **healthy hospitals:** WHO is currently developing a 'healthy hospital' initiative, and the Government and the NHS will consider the best ways of developing this from the points of view of patients, public and staff;

- **healthy environments:** the quality of the environment is also an important influence on health, and areas for particular attention include air and drinking water standards, and exposure to UV radiation.

Between them, these settings offer the potential to involve most of the people in the country.

THE SPECIAL ROLE OF THE NATIONAL HEALTH SERVICE

The goals, objectives and targets in the White Paper are for the nation as a whole, but the NHS has a central role. It is the main provider of high quality health care, and is therefore uniquely placed to promote health care in this country.

Improving overall health is not just a new management priority. It must become the central concern of all sectors of the NHS and should be integral to the work of every health professional in the NHS.

The Government's reforms of the NHS mean that health authorities are now able to respond strategically to the health needs of the populations they serve. The improved systems of accountability and the introduction of the concept of targets allow each part of the NHS to be actively managed, monitored and improved. The challenge now will be to establish a more direct link between health authories' work, and the gains in health both to individuals and to the population as a whole that result from it.

Health authorities' peformance will increasingly be measured against the efficient use of resources, and work with others, to achieve improvements in the health of local people. A strengthened link between planned interventions to improve health, and measurable changes in health will provide a new focus for health service planning and delivery to achieve this.

Regional Health Authorities will lead in ensuring that objectives are achieved regionally. RHAs are already setting regional health goals in addition to the national objectives. Hospital and Community Units, and primary and community health care services, will all need to be involved in work towards these objectives. The NHS Management Executive will look to RHAs to have District Health Authorities and Family Health Services Authorities:

- develop and agree local health and service targets (allowing Community Health Councils to comment and monitor performance)

- develop joint purchasing and investment plans to deliver health objectives
- focus on improving health promotion and health education
- develop and promote healthy alliances
- support professionals and promote good practice
- promote appropriate research and development.

The Department of Health and the NHS Management Executive will also:

- work with the professions nationally, and clinicians at local level, to explore ways of further developing health promotion in primary care
- examine ways of developing methods for setting and monitoring targets at local level
- commission handbooks on possible local approachs to Key Areas
- promote 'focus groups' to lead health authorities in each Key Area, and establish a network of "Health of the Nation" co-ordinators to ensure good communication between health authorities.

The NHS must set an example to others to show what can be achieved. A campaign of action to improve health education activity by the NHS will be developed for implementation from 1993. A task force has also been set up to review the NHS's achievements as a health employer and national and local targets may be set (for action in 1993) for NHS units to declare themselves healthy workplaces.

MONITORING, DEVELOPING AND REVIEWING THE STRATEGY

MONITORING AND RESEARCH

The strategy must be properly monitored and the tools to do this made available. A range of action to meet information and research needs, including major new health survey work, is being developed.

The Department of Health is building on existing initiatives to improve the information necessary for monitoring the success of the health strategy. To meet the research needs of the strategy, the Department of Health, in conjunction with a wide variety of research bodies, will direct research efforts towards the Key Areas and other areas which will allow the strategy to develop and broaden over time. The new NHS research and development strategy, launched during 1991, will reflect the priorities of the health strategy.

REVIEW

Systematic *review of progress* towards achievement of targets in Key Areas is central to "The Health of the Nation" initiative. As some health outcomes will take time to emerge clearly, it will therefore be important to monitor progress on the development of the structures and processes which will help generate the improvements in health.

The strategy also needs to continue to *develop:* some initial Key Areas may cease over time to continue to warrant priority status, or it may become appropriate to add new Key Areas. The Government therefore intends:

- *first*, that the **Department of Health will publish detailed appraisals of information and indicators needed to monitor progress in each Key Area** – these will consider what is needed, in what form and how they might be used;
- *second*, that **periodic reports on the progress of "The Health of the Nation" initiative as a whole be published, with reviews of the strategy on a regular basis.**

The Ministerial Committee on Health Strategy, supported by the three "Health of the Nation" Working Groups, will oversee the development and progress of the initiative as a whole.

CONCLUSION

"The Health of the Nation" initiative represents a major step forward in improving the health of the people of England. At its heart is the setting, for the first time in England, of initial priority *health* targets at which the nation as a whole can aim, together with new action to focus effort on the target areas. The White Paper starts the process: the sole measure of its success will be what it contributes to the achievement of these targets and others which are developed over time.

PREPARED BY THE DEPARTMENT OF HEALTH AND

PRINTED IN THE UK FOR HMSO Dd8398609 10/92 C1000 51-1111